Frequently Asked Questions:
Mobility Assistive Equipment National Coverage Determination,
Power Mobility Device Regulation and
Certificates of Medical Necessity (CMNs)

Section I. National Coverage Determination (NCD) for Mobility Assistive Equipment (MAE)

Q1.1 What does the MAE NCD address?

A1.1 CMS replaced the historical "bed or chair confined" criteria with function-based clinical criteria for MAE eligibility. The MAE NCD addresses coverage for the full range of MAE, from simple canes and walkers to multifunctional power wheelchairs.

Q1.2 How is the new policy of function-based criteria different from "bed or chair confined"?

A1.2 The function-based criteria CMS adopted focus on the beneficiary's ability to safely accomplish mobility- related activities of daily living in the home, such as toileting, grooming, and eating with and without the use of MAE. The previous standard focused on whether the beneficiary was "bed or chair confined." In some cases, this has been interpreted in the past to mean that a beneficiary cannot qualify for a wheelchair unless he or she is totally bed or chair bound.

Q1.3 How do clinicians determine whether patients qualify for the MAE benefit?

A1.3 The decision memo includes a coverage decision tree that physicians may use to determine whether a beneficiary needs an MAE, and to help ensure that the MAE prescribed to the beneficiary is appropriate to the beneficiary's needs.

Q1.4 Why does the MAE NCD offer a decision-tree model for determining whether and what kind of assistive device is appropriate for a beneficiary, rather than adopt distinct criteria for defined categories (i.e., manual wheelchairs, power wheelchairs, motorized scooters)?

A1.4 CMS believes that clinicians should retain the flexibility of fitting the equipment to the specific patient's circumstances so that the needs of the beneficiary are met in the most appropriate way.

Q1.5 Are coding, documentation and provider / supplier standards addressed in this NCD?

A1.5 No. This NCD is only one part of the agency's multi-pronged strategy on wheelchairs to address the clinical conditions of coverage, the creation of new power wheelchair codes, documentation requirements, as well as provider and supplier standards that are addressed in other CMS wheelchair initiatives.

Q1.6 When did the NCD become effective?

A1.6 The MAE NCD became effective on May 5, 2005. To view a copy, please visit the MAE page on the Coverage website at www.cms.hhs.gov/coverage/wheelchairs.asp and select the "National Coverage Determination" link.

Section II. The Power Mobility Device Regulation (CMS-3017-IFC)

Q2.1 What is a Power Mobility Device?

A2.1 A Power Mobility Device (PMD) is a class of durable medical equipment that includes both power wheelchairs and motorized scooters. The differences between the two types of vehicles are several. A power wheelchair is a four-wheeled motorized vehicle, that provides back support, and that is steered by an electronic device or joystick that controls direction and turning. A motorized scooter is a three or four-wheeled vehicle that provides little or no back support, and that is operated by a tiller.

Q2.2 What provisions in the PMD regulation were required by the Medicare Modernization Act of 2003 (MMA)?

A2.2 There are two provisions required by the MMA:

- Expanding the category of treating practitioners who may order power mobility devices to include some non-physician practitioners. Treating practitioners include physician assistants, clinical nurse practitioners or nurse specialists.
- The physician or treating practitioner must conduct a face-to-face examination before prescribing a PMD.

Q2.3 Apart from MMA requirements, what other key change is made by this regulation?

A2.3 This regulation removes the current requirement (section 410.38 of the Code of Federal Regulations) that in order to get a motorized scooter (power operated vehicle or POV), a beneficiary must be seen by a specialist in physical medicine, orthopedic surgery, neurology, or rheumatology. The regulation allows the beneficiary's physician or treating practitioner to prescribe either a power wheelchair or a power-operated vehicle.

Q2.5 How do the provisions of this regulation benefit physicians?

A2.5 The importance of the treating physician's role in the assessment and treatment of the beneficiary is reinforced by the requirement of a face-to-face examination. The recently published National Coverage Determination on Mobility Assistive Equipment provides greater transparency on how CMS contractors make coverage determinations. At the time of the examination, physicians who are familiar with these coverage guidelines can prescribe with greater certainty that the beneficiary will indeed receive the appropriate mobility device. We anticipate that physicians will find it simpler to provide supporting documentation from the medical record at the time the patient is seen, rather than having to complete a CMN. CMS is acknowledging the additional work of preparing and submitting the required documentation by giving the physician the opportunity to bill an additional amount for this service.

Q2.10 How will physicians and treating practitioners be paid for performing the face-to-face evaluation?

A2.10 Physicians and treating practitioners who submit claims for the face-to-face evaluation will be paid through the appropriate evaluation and management (E&M) code corresponding to the service they have provided.

Q2.11 What is the additional payment to physicians and treating practitioners for?

A2.11 Due to the requirement of this regulation that the physician or treating practitioner prepare and submit pertinent parts of the medical record to the DME supplier, an additional payment, distinct from the payment for the face-to-face examination, will be made. We will establish an add-on G Code (used in addition to an E&M code for the examination) to recognize the additional physician work and resources required to establish and document the need for the PMD. The payment amount for this new G code for 2005 is $21.60, adjusted by the geographic area where the service is provided, and is based on the physician fee schedule relative values for a level 1 established office visit (CPT 99211).

Q2.12Will CMS reconsider the provisions of this regulation if unforeseen problems become apparent?

A2.12 This regulation is being issued as an Interim Final with Comment (IFC). Thus, CMS will accept public comments and carefully consider them before finalizing this regulation.

Q2.13 How will CMS make sure that DME contractors appropriately implement the provisions of this regulation?

A2.13 Soon after the proposed rule is published, CMS will issue program instructions to its DME contractors.

Section III. Elimination of the Certificates of Medical Necessity (CMNs) for Manual Wheelchairs, Motorized Wheelchairs and Power Operated Vehicles

Q3.1 Why did CMS eliminate the CMN?

A3.1 CMS' experience has been that the CMN did not work as well as originally hoped. The CMN did not serve to help physicians better document their patient's clinical needs for a power wheelchair, it did not serve to ensure that beneficiaries always received appropriate equipment, nor did it serve as an effective deterrent to fraud and abuse.

Q3.2 Why is CMS relying on supplemental documentation from the medical record instead of using the CMN?

A3.2 We believe that the beneficiary's physician or treating practitioner is in the best position to evaluate and document the beneficiary's clinical condition and medical needs. Thus we feel that this regulation supports this important role, and that it is simpler for physicians and treating practitioners to submit copies of existing documentation from the medical record, rather than having to transcribe medical record information onto a separate form.

Q3.2 How should suppliers handle claims they have in process now?

A3.2 A complete CMN will no longer be required for claims with Dates of Service on or after May 5, 2005. If services were rendered prior to May 5, 2005, the DME supplier must submit a complete CMN.

Q3.3 How should suppliers handle claims during the transition period?

A3.3 The written prescription and supporting documentation required by the Interim Final Rule will replace CMNs for all types of wheelchairs and POVs. However, the Medicare contractors will not be able to fully implement this change until April 2006. Until Medicare's systems can be updated, DME suppliers will need to continue to submit a partially completed CMN with all claims. Currently, we expect to be able to update our systems in April 2006. Until then, for claims with dates of service on or after May 5, 2005, the DME suppliers should submit a CMN with only the information in Sections A and C completed. Sections B & D can be left blank. The treating physician or practitioner does not need to review the CMN. For claims with dates of service before May 5, 2005, the DME suppliers must submit a completed CMN signed and dated by the physician.

Q3.4 Does a supplier still need to collect and submit additional medical documentation?

A3.4 When a DMERC selects a claim for medical review, the supplier will be asked to submit the additional medical documentation that the physician or practitioner provided along with the prescription. An example of the documentation is a copy of the pertinent parts of the medical record from the health care professional who prescribed the PMD, which describe how the patient meets the clinical criteria for coverage as described in the NCD.

Section IV. DMERCs and Opportunities for Public Comment

Q4.1 How will CMS and the DMERCs formally communicate all of these changes?

A4.1 First, CMS has placed on display an interim final rule that establishes the overall framework contemplated by the MMA § 302. Shortly thereafter, CMS will release program instructions providing the authority to the DMERCs to implement the provisions of the interim final rule. Along with these instructions, a MedLearn Matters article, designed for the physician community, will be released, explaining physicians' roles and responsibilities. After that, the DMERCs will publish a suppliers' article explaining the new responsibilities of DME suppliers and will also publish a draft local coverage determination (LCD) formalizing all of these changes.

Q4.2 How can I share my ideas and comments with the DMERCs?

A4.2 The draft LCD will allow you to provide formal comments to the DMERCs.

Q4.3 What about CMS, can I give my comments to CMS?

A4.3 We are planning an Open Door Forum for early September. Please visit http://www.cms.hhs.gov/opendoor for more information as it becomes available. In addition, public comments may be submitted on the Interim Final Rule until [*specify date*].

Q4.4 This is a lot to understand. Do the DMERCs expect 100% compliance right away? Will there be a grace period where claims aren't reviewed?

A4.4 Gaining a full understanding of the intricacies of this change will take time. The DMERCs will be undertaking significant analysis of claims data to identify points of misunderstanding and areas which may need further intervention. However, if it is apparent that grossly aberrant billings are occurring, the DMERCs are obligated to take immediate action. This could mean claims review, further education, or both.